

Missouri Division of Medical Services

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Special Bulletin

SYSTEM MODIFICATIONS
EFFECTIVE SEPTEMBER 10, 2001

MC+ MANAGED CARE

PRIOR AUTHORIZATION(PA) PROCESS CHANGES

- Disposition Letters
- Denial of PA Requests
- Changes to Approved PAs
- State Agency PA Approvals

DRUG PA REQUESTS

CLAIM ATTACHMENT PROCESSING CHANGES

- Oxygen and Respiratory
Equipment Medical
Justification (OREMJ)
- Certificate of Medical
Necessity (CMN) for Durable
Medical Equipment (DME)
Providers Only

ELECTRONIC PA REQUEST AND CLAIM ATTACHMENTS VIA THE INTERNET

MC+ MANAGED CARE FOR THE WESTERN MC+ MANAGED CARE REGION

WESTERN REGION MC+ MANAGED CARE HEALTH PLANS

CHANGE IN ELIGIBILITY REQUIREMENTS

SYSTEM MODIFICATIONS EFFECTIVE SEPTEMBER 10, 2001

The Division of Medical Services, in conjunction with their fiscal agent, Verizon Information Technologies Inc., implemented several system modifications the weekend of September 8, 2001. These modifications included changes to prior authorization and claim attachment processing. All changes became effective September 10, 2001.

MC+ MANAGED CARE

MC+ Managed Care Health Plans may prior authorize certain services and may require attachments to certain claims for reimbursement. Providers should contact the health plan for their program policies. The information in this bulletin regarding prior authorizations and claim attachments refers to services provided on a fee-for-service basis.

PRIOR AUTHORIZATION (PA) REQUEST PROCESS CHANGES

The yellow PA Request form has been revised to allow for twelve (12) detail lines of service information. Instructions for completion are on the reverse side of the form. A copy of the revised form is attached ([Attachment I](#)).

As of September 10, 2001, the yellow PA Request form is no longer being returned after the request has been approved or denied.

With the exception of x-rays, dental molds, and photos, documentation submitted with the PA Request will not be returned. **Providers should retain a copy of the original PA Request and any supporting documentation submitted to the state for processing.**

Disposition Letter

Instead of a returned yellow PA Request form, a **disposition letter** will be sent to the requesting provider. The **disposition letter** will include all data pertinent to the PA Request. The **disposition letter** includes the PA number; the authorized provider number, name and address; the recipient's DCN, name, and date of birth; the procedure code, the from and through dates (if approved), and the units or dollars (if approved); the status of the PA Request on each detail line ("A"-approved; "C"-closed; "D"-denied; and "I"-incomplete); and the applicable Explanation of Benefit (EOB) reason(s), with the reason code description(s) on the reverse side of the letter. A sample copy of a disposition letter is attached ([Attachment II](#)).

Denial of PA Requests

The **disposition letter** will indicate a denied authorization by reflecting a status on each detail line of “D” for a denial of the requested service or “I” for a denial due to incomplete information on the form. With either denial status, “D” or “I”, a new PA Request form must be submitted for the request to be reconsidered.

Changes to Approved PAs

To request a change to an approved PA, providers are required to make the applicable changes on the **disposition letter**. The amended **disposition letter** must be signed and dated and submitted to the address listed in this bulletin. When changes to an approved PA are made on the **disposition letter**, the **disposition letter** is referred to as a Request For Change (RFC). Requests for reconsideration of any detail lines that reflect a “D” or “I” status must not be included on an RFC. Providers must submit a new PA Request form for reconsideration of denied detail lines.

When an RFC is approved, a **disposition letter** incorporating the requested changes will be sent to the provider. When an RFC is denied, the **disposition letter** sent to the provider will indicate the same information as the original **disposition**

letter that notified the provider of approval, with an EOB stating that the requested changes were considered but were not approved.

Providers *must not* submit changes to PA Requests until the **disposition letter** from the initial request is received.

Except as indicated below, PA Request forms and RFCs should be mailed to:

Verizon
Information Technologies Inc.
P. O. Box 5700
Jefferson City, MO 65102

State Agency PA Approvals

The approval process for PA Requests and RFCs has *not* been changed for services which must be approved by the Department of Health and Senior Services (DHSS).

PA Requests and RFCs for the Personal Care and Home Health programs’ services for children under the age of 21 *must* be submitted to DHSS, Bureau of Special Health Care Needs (BSHCN) for approval consideration. The BSHCN will submit the request to Verizon Information Technologies, Inc. The BSHCN staff will continue to *complete and submit* PA Requests and RFCs for Private Duty Nursing and Physical Disabilities Waiver programs’ services.

PA Requests and RFCs for AIDS Waiver and Personal Care programs’ services for individuals with HIV/AIDS will continue to be *completed and submitted* by the DHSS, Section of STD/HIV contract case management staff.

Personal Care and Aged and Disabled Waiver programs’ services will continue to be authorized by DHSS, Division of Senior Services staff through the Long Term Alternative Care Services (LTACS) system. The LTACS system has been upgraded to allow twelve (12) detail lines of service information.

DRUG PA REQUESTS

The information in this bulletin does *not* apply to the drug prior authorization process. Reference Section 13.7 of the pharmacy manual for information about drug prior authorizations.

CLAIM ATTACHMENT PROCESSING CHANGES

As of September 10, 2001, six claim attachments required for payment of certain services are being separately processed from the claim form. The six attachments are: Second Surgical Opinion Form; (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of

Restricted Recipient (SURS 118); Oxygen and Respiratory Equipment Medical Justification Form; and the Certificate of Medical Necessity (**only for the Durable Medical Equipment Program**).

Effective immediately, these six attachments must *not* be submitted with a claim form. These attachments must be mailed separately to:

Verizon
Information Technologies Inc.
P. O. Box 5900
Jefferson City, MO 65102

The data from the attachment is entered into Missouri's Medicaid Management Information System (MMIS) and processed for validity editing and Missouri Medicaid/MC+ program requirements. The policy requirements for any service that currently requires one of the listed attachments have not changed. The status of the attachment(s) will be reflected on a Remittance Advice (RA) similar to claim disposition. A sample copy of the attachment status RA page is attached ([Attachment III](#)).

When an attachment is approved, no EOB(s) or Exception(s) will be reflected on the applicable line of the attachment status RA page.

When an attachment is denied, the relevant EOB(s) and

Exception(s) will be indicated on the RA. Unless prohibited by the applicable program, the attachment can be corrected or additional information supplied on the attachment and resubmitted for consideration.

Providers do not need to alter their claim submittal process or wait for an attachment to be finalized on an RA before submitting the corresponding claim(s) for payment. A claim for services requiring one of the listed attachments will remain in suspense for up to sixty (60) days. When an attachment can be systematically linked to the claim, the claim will continue processing for adjudication. If after sixty (60) days a match is not found, the claim will deny for the missing attachment.

Example: Surgery which requires a Second Surgical Opinion Form is performed on a Medicaid/MC+ recipient, during an inpatient hospitalization, on December 5, 2001. The hospital submits a claim on December 21, 2001, without the Second Surgical Opinion Form. This claim will not deny based on the lack of the Second Surgical Opinion form but will suspend for up to sixty (60) days. The system will periodically check to determine if an approved attachment can be located to link to the hospital's claim.

The physician submits the

Second Surgical Opinion Form on December 22, 2001 and a claim on December 24, 2001. The data from the attachment is entered into the system and subsequently finalized in the system on December 31, 2001. During the next cycle the hospital's and the physician's claims will be linked to the attachment, and both claims will continue through the adjudication process.

An approved attachment is valid only for the procedure code indicated on the attachment. If a change in procedure code occurs, a new attachment must be submitted incorporating the new procedure code.

Oxygen and Respiratory Equipment Medical Justification Form (OREMJ)

The data from the OREMJ is entered into MMIS and processed for validity editing and Missouri Medicaid/MC+ program requirements. **Providers are required to include the type of service code (A, T, or 0 [zero]) in the procedure code field with the corresponding procedure code.**

The policy requirements for any service that currently requires an OREMJ have not changed. Once an OREMJ has been submitted and approved for twelve (12)

months from the prescription date, providers will not be required to submit the OREMJ with each claim submission or resubmission when the information on the claim matches the criteria (including the type of service) on the OREMJ. The claims will link up with the approved OREMJ and continue to process.

Certificate of Medical Necessity (CMN) for Durable Medical Equipment Providers Only

The data from the CMN for DME services is entered into MMIS and processed for validity editing and Missouri Medicaid/MC+ program requirements. **DME providers are required to include the type of service code (A, T, or 0 [zero]) in the procedure code field with the corresponding procedure code.**

The policy requirements for any service that currently requires a CMN in the DME program have not changed. Once the CMN has been submitted by a DME provider and is approved for six (6) months from the prescription date, any claim matching the criteria (including the type of service) on the CMN for that time period can be processed for payment, without a CMN attached. This will include all monthly claim submissions and any resubmissions.

ELECTRONIC PA REQUEST AND CLAIM ATTACHMENTS VIA THE INTERNET

Providers may now submit PA Requests and certain claim attachments via the Internet. PA Requests which cannot be submitted electronically via the Internet are those which require supporting documentation. *Example:* PA Requests for DME items when an invoice, evaluation or other documentation is required; and those that must be submitted to or are completed by another agency (reference the section in this bulletin regarding other state agencies processing PA Requests).

The claim attachments available for submission via the Internet include: Second Surgical Opinion Form; (Sterilization) Consent Form; Acknowledgment of Receipt of Hysterectomy Information; Medical Referral Form of Restricted Recipient (SURS 118), OREMJ and CMN (**for Durable Medical Equipment providers only**) when additional documentation is not required. The web site address for these submissions is www.emomed.com. Other options available on this web site include: claim submission; eligibility verification; inquiries on claim status, Remittance Advices(s), and check amounts; and credit adjustment(s). Other files available for viewing or downloading include: EOB

listing, Exception listing, and claims processing schedule.

Providers are required to contact Verizon Information Technologies' help desk at (573) 635-3559 to obtain authorization to access this site by completing the Application for Missouri Medicaid Internet Access Account. The Internet Access Account application may also be downloaded from the Missouri Medicaid Provider Manuals at www.dss.state.mo.us/dms. Reference Section 2.1.D. of the provider manuals for the download link.

Any provider wishing to take advantage of the options available through the web site must be an enrolled electronic billing provider and be approved for an Internet Access Account.

For verification of electronic billing provider status, providers may contact the Provider Relations Communication Unit at (800) 392-0938 or (573) 751-2896. Providers wishing to enroll as an electronic billing provider may contact Verizon Information Technologies' help desk at (573) 635-3559 or the Provider Enrollment Unit at (573) 751-2617.

MC+ MANAGED CARE FOR THE WESTERN MC+ MANAGED CARE REGION

Effective February 1, 2002, the State of Missouri will continue a managed care health care service delivery program in Cass, Clay, Henry, Jackson, Johnson, LaFayette, Platte, Ray and St. Clair counties. MC+ managed care serves individuals meeting specified eligibility criteria. Refer to Section 1.5 B of the Provider Manual for a listing of MC+ managed care eligibles.

**WESTERN REGION MC+
MANAGED CARE
HEALTH PLANS**

New contracts have been awarded for the Western MC+ managed care region. The following MC+ health plans will provide services for the MC+ Managed Care Program in the Western region.

**Blue Cross Blue Shield of
Kansas City Blue
Advantage Plus Health Plan**
2301 Main Street, 3rd Floor
Kansas City, MO 64108
Provider Relations:
1-888-279-8186
Fax: 816-395-3811

**Family Health Partners
Health Plan**
215 W. Pershing Road
6th Floor

P.O. Box 411806
Kansas City, MO 64108
Provider Relations:
1-800-347-9363
Fax: 816-471-1832

FirstGuard Health Plan
3801 Blue Parkway
Kansas City, MO 64130
Provider Relations:
1-888-828-5698
Fax: 816-922-7243

**HealthCare USA Health
Plan**
10 S. Broadway Street
Suite 1200
St. Louis, MO 63102
Provider Relations:
1-800-625-7602
Fax: 573-761-7380

**CHANGE IN
ELIGIBILITY
REQUIREMENTS**

The Centers for Medicare and Medicaid Services (CMS) approved the State of Missouri's request to change eligibility requirements under Section 1931 of the Social Security Act. As a result of this change, effective January 1, 2002, Uninsured Custodial Parents below 100 percent of the federal poverty level will no longer be a part of the 1115 Waiver, but will be eligible under Medical Assistance for Families. Their ME Codes will change from ME Code 79 to ME Code 05 until a new ME Code of 82 is effective April 1, 2002.

Individuals affected by this

change will no longer be subject to MC+ co-payment requirements but will be subject to all cost-sharing and shared prescription dispensing fee requirements of this category of assistance. Providers should refer to Section 13 of the Provider Manuals for detailed information regarding cost-sharing and shared prescription dispensing fee requirements.

Provider Communications
(800) 392-0938
or
(573) 751-2896